# Smithers Community Healthare, PC Patient Contact Form

Patient Name: (First) Steve (Last) Blevins (MI) R.
Patient Address: 2231 Camargo Rd.
City: Mt. Sterling State: Ky Zip: 40353
Home Phone: (859) 585-5242 Cell/Pager:
Birthdate: 03-03-1972 Age: 43 Sex: (M) F
Country of Birth: US. Country of Parents' Birth: US.

**Employment and Insurance Information:**
Patient Employer: SCIF Occupation: Painter
Employer Address: 2231 Camargo Rd.
City: Mt. Sterling State: Ky Zip 40353
Work phone No: (859) 585-5242 Ext. ~
Social Security: 236-06-6128 Drivers License: B93-583-067
Primary Insurance Carrier: ~
Policy #: Group #:
Primary Insurance Address:
City: State: Zip
Primary Insurance Phone #:

**In Case of Emergency:**
Name: Rick Jessie Relationship: uncle Phone:
Patient's Spouse: ~ Phone:
Family Physician: ~ Phone:
Referred by: Rick Jessie

FDLMP (first day of last menstrual period): ~
Are you pregnant or trying to become pregnant?: ~

# Smithers Community Healthcare, PC

## *New Patient* Intake Form for pain management

Your completed intake paperwork helps your physician and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (844) 373-7883 if you have any question on how to complete any section on this form.

### Patient Information

Today's date: 9-02-15

Your name: Steve Blevins Date of Birth: 03-03-1972 Age: 43

Referring Physician: — Primary Care Physician: none.

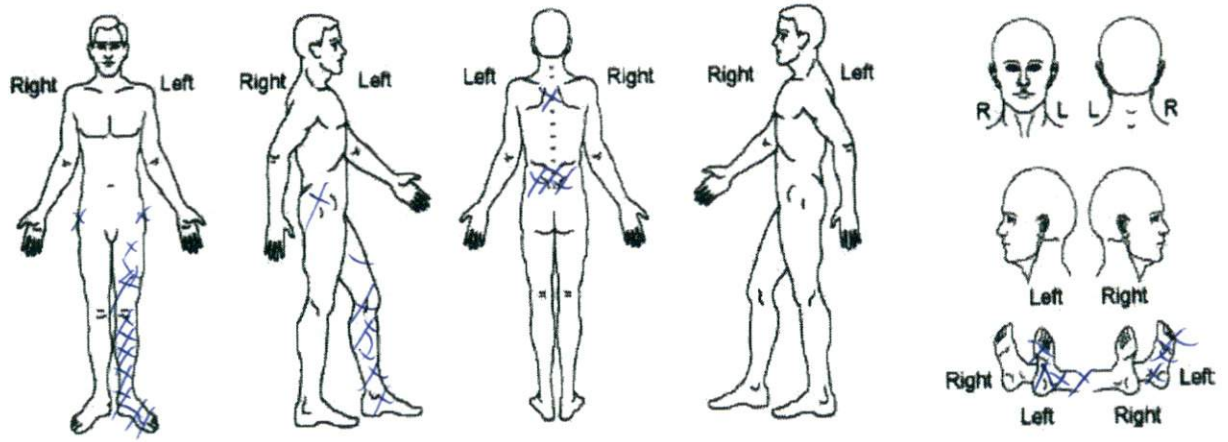
### Pain History

Chief Complaint (Reason for your visit today)? Pain - All over

Does this pain radiate? If so where? everywhere

Please list any additional areas of pain: Left Leg - Hips - Back - Left Foot

Use this diagram to indicate the area of your pain. Mark the location with an "X"




### Onset of Symptoms

Approximately when did this pain begin? My Back Pain has Been 10 years or Better

What caused your current pain episode? Motorcycle accident

How did your current pain episode begin? ☐ Gradually ☑ Suddenly

Since your pain began how has it changed? ☐ Improved ☑ Worsened ☐ Stayed the same

## Pain Description

**Check all of the following that describe your pain:**

- ☑ Dull/Aching
- ☑ Hot/Burning
- ☑ Shooting
- ☑ Stabbing/Sharp
- ☑ Cramping
- ☑ Numbness
- ☑ Spasming
- ☑ Throbbing
- ☑ Squeezing
- ☑ Tingling/Pins and Needles
- ☑ Tightness

**When is your pain at its worst?**

- ☐ Mornings
- ☐ Daytime
- ☐ Evenings
- ☐ Middle of the night
- ☑ Always the same

**How often does the pain occur?**

- ☑ Constant
- ☐ Changes in severity but always present
- ☐ Intermittent (comes and goes)

**If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?**

Right Now 10 The Best It Gets 10 The Worst It Gets 10

## Mark the effect each of the following have on your pain level - ☑

| | Increases | Decreases | No Change |
|---|---|---|---|
| Bending Backward | ☑ | ☐ | ☐ |
| Bending Forward | ☑ | ☐ | ☐ |
| Changes in Weather | ☑ | ☐ | ☐ |
| Climbing Stairs | ☑ | ☐ | ☐ |
| Coughing/Sneezing | ☑ | ☐ | ☐ |
| Driving | ☑ | ☐ | ☐ |
| Lifting Objects | ☑ | ☐ | ☐ |
| Looking upward | ☑ | ☐ | ☐ |
| Looking downward | ☑ | ☐ | ☐ |
| Rising from seated position | ☑ | ☐ | ☐ |
| Sitting | ☑ | ☐ | ☐ |
| Standing | ☑ | ☐ | ☐ |
| Walking | ☑ | ☐ | ☐ |

What other factors worsen or affect your pain which is not mentioned above?

## Associated Symptoms

| | NO | Yes | Comments |
|---|---|---|---|
| Numbness/Tingling | ☐ | ☑ | Where? |
| Weakness in the arm/leg | ☐ | ☑ | |
| Balance Problems | ☐ | ☑ | |
| Bladder Incontinence | ☑ | ☐ | |
| Bowel Incontinence | ☑ | ☐ | |
| Joint Swelling/Stiffness | ☐ | ☑ | |
| Fevers/chills | ☑ | ☐ | |

## Please mark all of the following treatments you have used for pain relief: ☑

| | No Change | Worsened Pain | Helped Pain |
|---|---|---|---|
| Spine Surgery | ☐ | ☐ | ☐ |
| Physical Therapy | ☐ | ☐ | ☐ |
| Chiropractic Care | ☐ | ☐ | ☐ |
| Psychological Therapy | ☐ | ☐ | ☐ |
| Brace Support | ☐ | ☐ | ☐ |
| Acupuncture | ☐ | ☐ | ☐ |
| Hot/Cold Packs | ☐ | ☐ | ☑ |
| Massage Therapy | ☐ | ☐ | ☐ |
| Medications | ☐ | ☐ | ☑ |
| TENS Unit | ☐ | ☐ | ☐ |

Other _____

## Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - _____

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

## Diagnostic Tests and Imaging

**Mark all of the following tests that you have related to your current pain complaints:**

☐MRI of the: _____ Date: _____

☐X-Ray of the: _____ Date: _____

☐CT Scan of the: _____ Date: _____

☐EMG/NCV study of the: _____ Date: _____

☐Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

**Mark the following physicians or specialists you have consulted for your current pain problem(s):**

| | | |
|---|---|---|
| ☐ Acupuncturist | ☐ Neurosurgeon | ☐ Psychiatrist/Psychologist |
| ☐ Chiropractor | ☑ Orthopedic Surgeon | ☐ Rheumatologist |
| ☐ Internist | ☐ Physical Therapist | ☐ Neurologist |

☐ Other _____

## Past Medical History

**Please list the names of other Pain Physicians you have seen in the past?** William Bacon,

**Mark the following conditions/diseases that you have been treated for in the past:**

**General Medical**
- ☐ Cancer – Type _____
- ☐ Diabetes – Type_____

**Cardiovascular/Hematologic**
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

**Gastrointestinal**
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

**Urological**
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

**Neuropsychological**
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

**Head/Ears/Eyes/Nose/Throat**
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

**Respiratory**
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

**Musculoskeletal/Rheumatologic**
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

**Other Diagnosed Conditions**
- ☐ Sciatic Nerve Damage
- ☐ Broken Leg & Foot
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

## Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) N/A Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

## Current Medications

**Are you currently taking any blood thinners or anti-coagulants?** ☐ YES ☑ No

**If YES**, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

**Please list all medications you are currently taking including vitamins. Attach additional sheet if required:**

| | Medication Name | Dose | Frequency |
|---|---|---|---|
| 1) | Oxycodone | 30 mg | 5-6-a day |
| 2) | Tizanidine | 4 mg | 1 or 2 at night |
| 3) | Methadone | 5 mg | 2 a day |
| 4) | Gabapentin | ? 600 mg | ? Q.I.D |
| 5) | | | |
| 6) | | | |
| 7) | | | |
| 8) | | | |
| 9) | | | |
| 10) | | | |

Out of Rx - 3 months

**Please list all past pain medications that you have been on at any point for your current pain complaints?**

| | Medication Name | Dose | Frequency |
|---|---|---|---|
| 1) | Oxycodone | 30 mg | 5-6-a day |
| 2) | Methadone | 5-10 mg | 2-4 times a day |
| 3) | MS Contin | unsure | unsure |
| 4) | | | |
| 5) | | | |

## Allergies

**Do you have any drug/medication allergies?** ☐ Yes ☑ No

**If so, please list all medications you are allergic to:**

| | Medication Name | Allergic Reaction |
|---|---|---|
| 1) | N/A | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

## Family History

**Mark all appropriate diagnoses as they pertain to your first degree relatives:**

☐ Arthritis ☐ Cancer ☐ Diabetes

☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems

☐ Liver Problems ☐ Osteoporosis ☐ Rheumatoid arthritis

☐ Seizures ☐ Stroke

☐ Other Medical Problems: _____

☐ I have no significant family medical history

## Social History

Occupation: Painter, Garage When was the last time you worked? about

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☑ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☑ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☑ No ☐ Yes

**Alcohol Use:**

☐ Social Use ☐ History of alcoholism ☐ Current alcoholism ☑ Never

☐ Daily use of alcohol

**Tobacco Use:**

☐ Current user ☐ Former user ☐ Never used

☑ Packs per day? 1 ☐ How many years? 20 ☑ Quit Date: Soon

**Illegal Drug Use:**

☑ Denies any illegal drug use ☐ Currently uses illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? ☐ Yes ☑ No

## Review of Systems

**Mark the following symptoms that you currently suffer from:**

| | | | |
|---|---|---|---|
| **Constitutional:** | ☐ Chills | ☐ Difficulty sleeping | ☐ Easy bruising |
| | ☐ Night Sweats | ☑ Fatigue | ☐ Fevers |
| | ☐ Insomnia | ☑ Low sex drive | ☐ Tremors |
| | ☐ Unexplained Weight Gain | | ☐ Weakness |
| | ☐ Unexplained Weight Loss | | |
| **Eyes:** | ☐ Recent Visual changes | | |
| **Ears/Nose/Throat/Neck:** | ☐ Dental Problems | ☐ Earaches | ☐ Hearing Problems |
| | ☐ Nosebleeds | ☐ Sinus problems | |
| **Cardiovascular:** | ☐ Chest Pain | ☐ Bleeding Disorder | ☐ Blood Clots |
| | ☐ Fainting | ☐ Palpitations | ☑ Swelling in feet |
| | ☐ Shortness of breath during sleep | | |
| **Respiratory:** | ☐ Cough | ☐ Wheezing | ☐ Shortness of breath |
| **Gastrointestinal:** | ☐ Constipation | ☐ Acid Reflux | ☐ Abdominal Cramps |
| | ☐ Diarrhea | ☐ Nausea/Vomiting | ☐ Hernia |
| **Musculoskeletal:** | ☑ Back Pain | ☑ Joint Pains | ☑ Joint Stiffness |
| | ☑ Joint Swelling | ☑ muscle spasms | ☐ Neck Pain |
| **Genitourinary/Nephrology:** | ☐ Flank Pain | ☐ Blood in Urine | ☐ Painful Urination |
| | ☐ Decreased Urine Flow/Frequency/Volume | | |
| **Neurological:** | ☐ Dizziness | ☐ Headaches | ☐ Tremors |
| | ☐ Numbness/Tingling | | ☐ Seizures |
| **Psychiatric:** | ☐ Depressed Mood | ☐ Feeling Anxious | ☐ Stress Problems |
| | ☐ Suicidal Thoughts | ☐ Suicidal Planning | |
| | ☐ Thoughts of Harming Others | | |

☑ All other review of systems negative

☑ Reviewer _____

SB2_000009

# SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have mood swings? | ○ | ○ | ○ | ○ | ○ |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | ○ | ○ | ○ | ○ | ○ |
| 3. How often have you felt impatient with your doctors? | ○ | ○ | ○ | ○ | ○ |
| 4. How often have you felt that things are just too overwhelming that you can't handle them? | ○ | ○ | ○ | ○ | ○ |
| 5. How often is there tension in the home? | ○ | ○ | ○ | ○ | ○ |
| 6. How often have you counted pain pills to see how many are remaining? | ○ | ○ | ○ | ○ | ○ |
| 7. How often have you been concerned that people will judge you for taking pain medication? | ○ | ○ | ○ | ○ | ○ |
| 8. How often do you feel bored? | ○ | ○ | ○ | ○ | ○ |
| 9. How often have you taken more pain medication than you were supposed to? | ○ | ○ | ○ | ○ | ○ |
| 10. How often have you worried about being left alone? | ○ | ○ | ○ | ○ | ○ |
| 11. How often have you felt a craving for medication? | ○ | ○ | ○ | ○ | ○ |
| 12. How often have others expressed concern over your use of medication? | ○ | ○ | ○ | ○ | ○ |



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| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 13. How often have any of your close friends had a problem with alcohol or drugs? | ○ | ○ | ○ | ○ | ○ |
| 14. How often have others told you that you had a bad temper? | ○ | ○ | ○ | ○ | ○ |
| 15. How often have you felt consumed by the need to get pain medication? | ○ | ○ | ○ | ○ | ○ |
| 16. How often have you run out of pain medication early? | ○ | ○ | ○ | ○ | ○ |
| 17. How often have others kept you from getting what you deserve? | ○ | ○ | ○ | ○ | ○ |
| 18. How often, in your lifetime, have you had legal problems or been arrested? | ○ | ○ | ○ | ○ | ○ |
| 19. How often have you attended an AA or NA meeting? | ○ | ○ | ○ | ○ | ○ |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | ○ | ○ | ○ | ○ | ○ |
| 21. How often have you been sexually abused? | ○ | ○ | ○ | ○ | ○ |
| 22. How often have others suggested that you have a drug or alcohol problem? | ○ | ○ | ○ | ○ | ○ |
| 23. How often have you had to borrow pain medications from your family or friends? | ○ | ○ | ○ | ○ | ○ |
| 24. How often have you been treated for an alcohol or drug problem? | ○ | ○ | ○ | ○ | ○ |

*Please include any additional information you wish about the above answers. Thank you.*



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# Smithers Community Healthcare, PC Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Smithers Community Healthcare, PC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Smithers Community Healthcare, PC to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Smithers Community Healthcare, PC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Smithers Community Healthcare, PC to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Smithers Community Healthcare, PC to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Smithers Community Healthcare, PC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and by fax.

Signed: Steve Blevins Date: 9-2-15

# Smithers Community Healthcare, PC Consent for Treatment

I certify that the above information is accurate, complete and true.

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Signed: Steve Blevins Date: 7-2-15

**For Healthcare / Medical Industry Purpose**

Customer Support (888) 493-2209
customersupport@tlo.com
Logged in as : WENDELL@PROTECTPAINCARE.ORG
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**Favorites**
**User Tips**
**Sign Out**

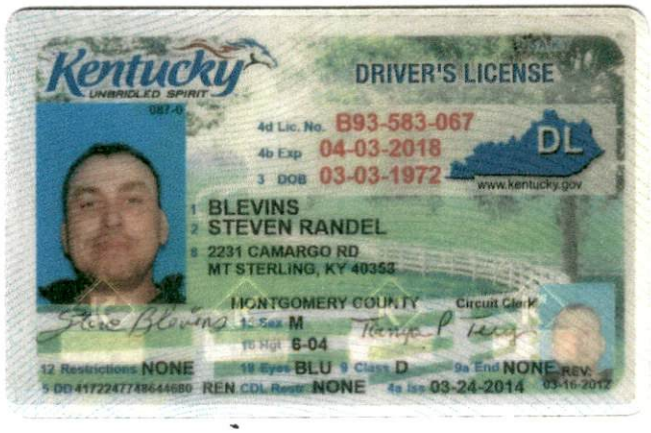
Your Current Reference ID: **NONE**

***We're sorry, there were no results found for people named STEVE R BLEVINS who have used SSN: 236-06-6128 born on 03/03/1972 in the United States.***

10-01-15

SS# 236-06-6128

PH# 859-585-5042
859-498-9970



# Compliance Audit REMS Screening, Inc.

Patient Name: Steve Blevins | Chart Number: | Payer: cash | Primary DOB: 3/3/1972

**Code: 99408/99409 G0396/G0397 H0049/H0050** **ICD9:** _____ Notify:

At age 16 (before pain), did you sleep > 5 hours nightly? Yes
Do you get at least 5 hours sleep in a Bad Night? No
SLEEP ALERT: Nights each week you don't get at least 5 hours sleep uninterrupted by pain? 7

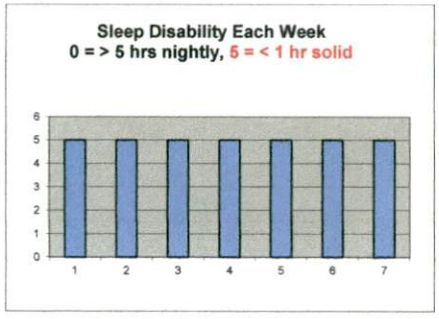
| | Sleep Disability |
|---|---|
| Sunday | 5 |
| Monday | 5 |
| Tuesday | 5 |
| Wednesday | 5 |
| Thursday | 5 |
| Friday | 5 |
| Saturday | 5 |

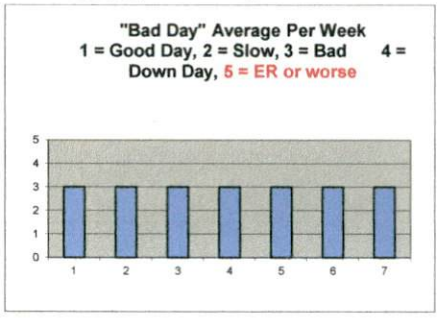
Continuous Sleep Ratings
6 hrs = 0
5 hrs = 1
4 hrs = 2
3 hrs = 3
2 hrs = 4
1 hr or less = 5

Explain 4 Categories of Pain Below

| | |
|---|---|
| How many "Down Days" per week? | 0 |
| How many "Bad Days" per week? | 7 |
| How many "Slow Days" per week? | 0 |
| How many "Good Days" per week? | 0 |

| | |
|---|---|
| Sunday | 3 |
| Monday | 3 |
| Tuesday | 3 |
| Wednesday | 3 |
| Thursday | 3 |
| Friday | 3 |
| Saturday | 3 |




Status: Improving (No change, improving, worsening)

By signing this document I affirm that I answered all of the above questions honestly. I also understand that if I lied about any of the questions listed above that I may be charged with an attempt to receive a controlled substance by fraud. I understand that I am legally obligated to tell the truth [redacted] and because of this I have answered all of the above questions truthfully.

I certify the truthfulness of my answers.

10-01-15 X Steve Blevins

Narcotics Auditor | Patient Signature

**Compliance Audit** 

# Pre-Screening Audit REMS Screening, Inc.

Patient Name: Steve Blevins DOB: 3/3/1972

## 96152: Diversion Risk Stratification: Honesty is Vital

Source: Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med 2005; 6(6):432-442

| | | Yes/No | Score |
|---|---|---|---|
| 1 | Is there a history of substance abuse in your family? | | |
| | **Alcohol?** | No | |
| | **Illegal drugs?** | No | |
| | **Other (huffing gas)** | No | |
| 2 | Do you have a history of substance abuse? | | |
| | **Alcohol?** | No | |
| | **Illegal drugs?** | No | |
| | **Prescription drugs?** | No | |
| 3 | Is your age between 16 and 45? | | |
| | **16-45?** | Yes | 1 |
| 4 | Were you a victim of preadolescent (childhood) sexual abuse? | | |
| | **Sex Abuse?** | No | |
| 5 | Do you have a history of any of the following conditions: | | |
| | **ADD, OCD, Bipolar, Depression?** | No | |
| | **Total:** | | 1 |
| | **Patient Risk Level:** | Low | |
| | **Drug Screen Protocol:** | 2 - 3 UDT Per Year | |

| Risk Level | | Medically Recommended Urine Drug Screen Protocol |
|---|---|---|
| Score | Risk | |
| 0-3 | Low | 2 - 3 UDT Per Year |
| 4-7 | Moderate | 4 UDT Per Year |
| 8+ | High | 4 Plus 1 to 2 Random UDT Per Year |

| | |
|---|---|
| Have you had, or do you have suicudal thoughts or tendencies? | **No** |
| Have you ever snorted or injected any substance? | **Yes** |
| Have you taken drugs not Rxed for you? | **Yes** |
| Have you ever been tempted to experiment with your meds? (Crush, snort or shoot up) | **No** |
| Have you ever received addiction help (AA/NA)? | **No** |
| Have you ever been asked to sell or share your medication? | **No** |
| Do you have friends who tempt you to abuse/misuse narotics? | **No** |
| Have you ever stolen meds or had any stolen from you? | **No** |
| Have you ever borrowed any meds from someone? | **Yes** |
| Are you currently pregnant? | **N/A** |
| Have you ever received treatment at a methadone or suboxone treatment center? | **No** |
| Track Marks? (Examine Patient) | **No** |

Have you ever been charged with, or convicted of any criminal offense? **No**
If "Yes" detail below:

By signing this document I affirm that I answered all of the above questions honestly. I also understand that if I lied about any of the questions listed above that I may be charged with an attempt to receive a controlled substance by fraud. I understand that I am legally obligated to tell the truth to the HOPE Clinic and because of this I have answered all of the above questions truthfully.

I certify the truthfulness of my answers.

NW 10-01-15 | X Steve Blevins

Narcotics Auditor Patient Signature

CABINET FOR HEALTH AND FAMILY SERVICES
Commonwealth of Kentucky
275 East Main Street
Frankfort, KY 40621-0001

**Drug Enforcement Branch - KASPER**

***Patient Controlled Substance Report***

Between 09/29/2014 and 09/29/2015

JW 10-01-15

**Requestor Name :** SMITHERS JOEL

**Request # :** 21006118

**Patient Name:** BLEVINS, STEVE

**Interstate Data not available for all states**
**Requestor's Role is not permitted by:** IL,SC,VA
**No response from:** AL

**Patients that matched the search criteria:**

| Pat ID | Patient Name | Date of Birth | Address |
|---|---|---|---|
| 1 | BLEVINS, STEVE | 3/3/1972 | 725A LORENE CIRCLE, MT. STERLING, KY |

| Date Filled | Drug Name | Patient DOB | Qty | Days | Prescriber Name | Prescriber DEA City | Pharmacy Name | Pharmacy City | Rpt To | Pat ID |
|---|---|---|---|---|---|---|---|---|---|---|
| 08/13/2015 | Oxycodone/Acetaminophen 325MG/5MG | 03/03/1972 | 34 | 3 | Prabhu, Ashwin | Lexington | Whitaker Pharmacy | Mount Sterling | KY | 1 |
| 08/17/2015 | Oxycodone Hcl 10MG | 03/03/1972 | 60 | 10 | Chattha, Anup | Mt Sterling | Whitaker Pharmacy | Mount Sterling | KY | 1 |
| 08/25/2015 | Oxycodone Hcl 10MG | 03/03/1972 | 60 | 10 | Chattha, Anup | Mt Sterling | Whitaker Pharmacy | Mount Sterling | KY | 1 |
| 09/15/2015 | Oxycodone Hcl 10MG | 03/03/1972 | 60 | 10 | Chattha, Anup | Mt Sterling | Whitaker Pharmacy | Mount Sterling | KY | 1 |
| 09/24/2015 | Oxycodone Hcl 10MG | 03/03/1972 | 60 | 10 | Rollins, James | Mt Sterling | Whitaker Pharmacy | Mount Sterling | KY | 1 |

**The information in this report is based upon Schedule II through V controlled substance records reported by dispensers. Data should appear on KASPER reports within two to three business days after dispensing.*
**The records listed in the report are based on the patient identification information entered by the report requestor, and if not sufficiently unique may result in the report including records for multiple patients. Please verify the information in the report by contacting the prescribers and/or dispensers listed.*
**If the controlled substance records on this report appear to be in error, the patient or provider should contact the dispenser to determine if the information was reported accurately. If the dispenser certifies the information was reported accurately, the dispenser can contact the Drug Enforcement and Professional Practices Branch at 502-564-7985 to investigate the error.*
**The information in this report is intended for informational use only by the person authorized to request the report. Intentional disclosure of the report or data to someone not authorized to obtain the data is a Class B Misdemeanor.*

**10/01/2015**

**Report Restrictions – A practitioner or pharmacist may share the report with the patient or person authorized to act on the patient's behalf and place the report in the patient's medical record, with the report then being deemed a medical record subject to the same disclosure terms and conditions as an ordinary medical record. (KRS 218A.202)**

# Brief Pain Inventory (Short Form)

~~Study ID#~~ BP 147/68 B 115 96 bpm ~~Hospital#~~ O2 96% SpO2 W 271.

Do not write above this line

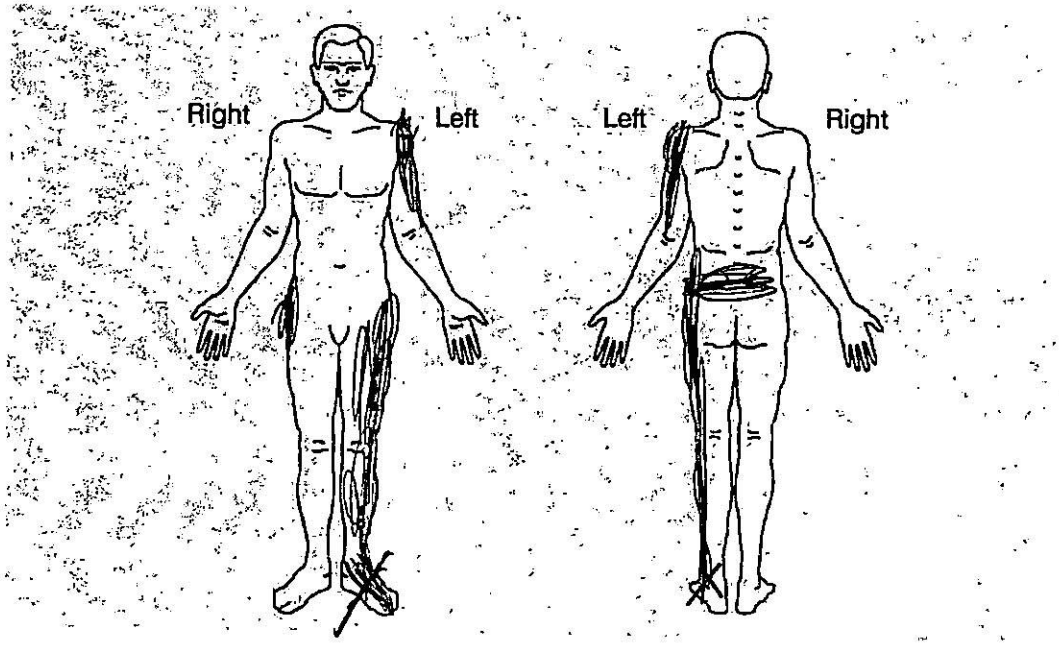
Date: 10/1/15 Time: 10:20 A.M.

Name: Blevins Last Steven First R Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.




3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Pain as bad as you can imagine |

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Pain as bad as you can imagine |

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Pain as bad as you can imagine |

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Pain as bad as you can imagine |

7) What treatments or medications are you receiving for your pain?

oxycodone 30 mg)

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
|---|---|---|---|---|---|---|---|---|---|---|
| No relief | | | | | | | | | | Complete relief |

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

B. Mood:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

C. Walking ability:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

D. Normal work (includes both work outside the home and housework):

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

E. Relations with other people:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

F. Sleep:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

G. Enjoyment of life:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not interfere | | | | | | | | | | Completely interferes |

Reference: Brief Pain Inventory. Charles Cleeland, PhD. Pain Research Group. Copyright 1991. Used with permission.

Pt reports lost MS Contin Rx in truck. Has taken & tol. all other Rx well, except for needing refills.

J, D.O. 10.1.15

A7012-AS-8

## Review of Systems

**Mark the following symptoms that you currently suffer from:**

| | | | |
|---|---|---|---|
| **Constitutional:** | ☐ Chills | ☐ Difficulty sleeping | ☐ Easy bruising |
| | ☐ Night Sweats | ☐ Fatigue | ☐ Fevers |
| | ☐ Insomnia | ☑ Low sex drive | ☐ Tremors |
| | ☐ Unexplained Weight Gain | | ☐ Weakness |
| | ☐ Unexplained Weight Loss | | |
| **Eyes:** | ☐ Recent Visual changes | | |
| **Ears/Nose/Throat/Neck:** | ☑ Dental Problems | ☐ Earaches | ☐ Hearing Problems |
| | ☐ Nosebleeds | ☐ Sinus problems | |
| **Cardiovascular:** | ☐ Chest Pain | ☐ Bleeding Disorder | ☐ Blood Clots |
| | ☐ Fainting | ☐ Palpitations | ☐ Swelling in feet |
| | ☐ Shortness of breath during sleep | | |
| **Respiratory:** | ☐ Cough | ☐ Wheezing | ☐ Shortness of breath |
| **Gastrointestinal:** | ☐ Constipation | ☐ Acid Reflux | ☐ Abdominal Cramps |
| | ☐ Diarrhea | ☐ Nausea/Vomiting | ☐ Hernia |
| **Musculoskeletal:** | ☑ Back Pain | ☑ Joint Pains | ☑ Joint Stiffness |
| | ☑ Joint Swelling | ☑ muscle spasms | ☐ Neck Pain |
| **Genitourinary/Nephrology:** | ☐ Flank Pain | ☐ Blood in Urine | ☐ Painful Urination |
| | ☐ Decreased Urine Flow/Frequency/Volume | | |
| **Neurological:** | ☐ Dizziness | ☐ Headaches | ☐ Tremors |
| | ☐ Numbness/Tingling | | ☐ Seizures |
| **Psychiatric:** | ☐ Depressed Mood | ☐ Feeling Anxious | ☐ Stress Problems |
| | ☐ Suicidal Thoughts | ☐ Suicidal Planning | |
| | ☐ Thoughts of Harming Others | | |

☑ All other review of systems negative

☑ Reviewer J.R.C. 10.9.15

# Form 1.1 Initial Pain sessment tool

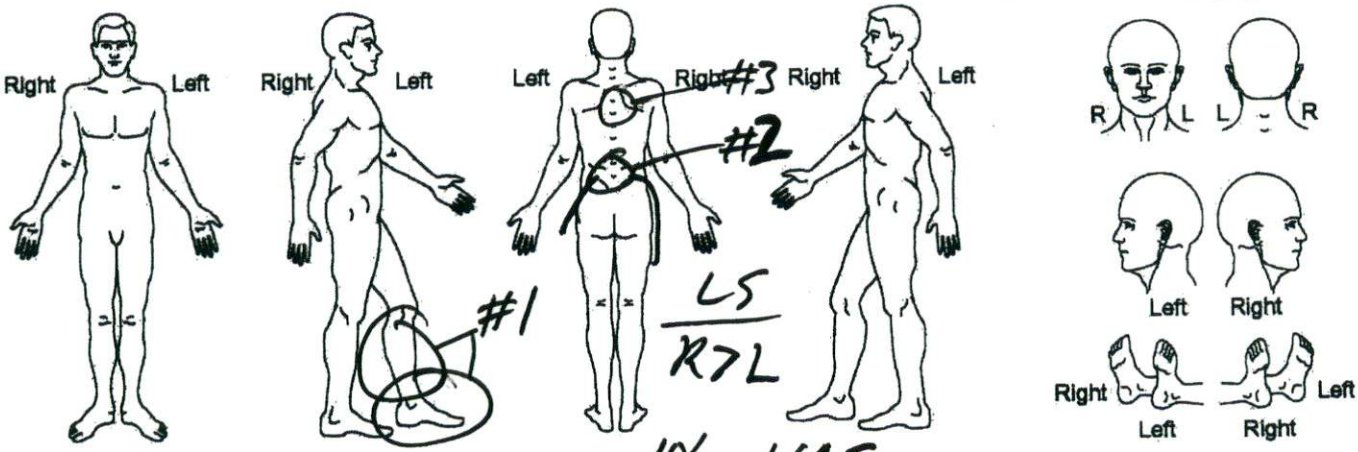
Patient's Name Steven Blevins Age 43 Date 9.2.15 Room 1

Diagnosis 724.4, 724.1, 805.2 Physician J.D.O.

Nurse

1. LOCATION: Patient or nurse mark drawing.

274.6 97% 5L O2 134/86 95 HR




2. INTENSITY: Patient rates the pain. Scale used 10/10 VAS

Present pain: 10 Worst pain gets: 10 Best pain gets: 5-6 Acceptable level of pain: 3-4

3. IS THIS PAIN CONSTANT? ✓ YES; ___ NO IF NOT, HOW OFTEN DOES IT OCCUR? ___

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) ___

5. ONSET, DURATION, VARIATIONS, RHYTHMS: ___

6. MANNER OF EXPRESSING PAIN: ___

7. WHAT RELIEVES PAIN? ___

8. WHAT CAUSES OR INCREASES THE PAIN? ___

9. EFFECTS OF PAIN: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) ___

Sleep 2-3-4 awakenings/night d/t pain.

Appetite ___

Physical activity ___

Relationship with others (e.g., irritability) ___

Emotions (e.g., anger, suicidal, crying) ___

Concentration ___

Other ⊖ liver or kidney Dz. ⊖ OSA.

10. OTHER COMMENTS: Motorcycle accident 3wks ago c multiple FX's to ⓛ LE & foot.

11. PLAN: Stop Methadone. Start MS Contin. Start Nortriptyline.

Joel A Smithers DO
445 Commonwealth Blvd E
Ste A
Martinsville, VA 24112
(844)373-7883

# Discharge Summary (Chart Copy)

Date: 09/02/2015
Time: 12:10 p.m.

Treating Provider: Joel Smithers, DO  Phone:  Fax:

Provider Signature: <Electronically signed by Joel Smithers,DO.>

Patient Name: Steven Blevins  MR#: 1URXJYH27  Account:

Patient Address:  Phone:

Your Discharge Instructions:

NARCOTIC MEDICATION

Your Prescriptions:

MS Contin 30 Milligram # 60 Tablets
1 TABLET EVERY 12 HOURS. (0 Refills).Printed.
OxyCODONE HCl 30 Milligram # 120 Tablets
1/2-1 TABLET EVERY 4 TO 6 HOURS AS NEEDED FOR BREAKTHROUGH PAIN. (0 Refills).Printed.

Physician Name:  Specialty:

Address:  Phone:

Follow-up Notes:

I understand that the emergency care I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician(s) as indicated for continued and complete medical diagnosis, care, and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the follow-up physician indicated above.

**I have read and understand the above, received a copy of applicable instruction sheets, and will arrange for follow-up care.**

Signature Patient/Parent/Guardian Date/Time

Signature Instructed By Date/Time 9-2-15

Joel A Smithers DO
445 Commonwealth Blvd E
Ste A
Martinsville, VA 24112
(844)373-7883

# Discharge Summary (Chart Copy)

Date: 09/02/2015
Time: 12:06 p.m.

| | | | | | |
|---|---|---|---|---|---|
| Treating Provider: | Joel Smithers, DO | Phone: | | Fax: | |
| Patient Name: | Steven Blevins | MR#: | 1URXJYH27 | Account: | |
| Patient Address: | | Phone: | | | |

**Additional Discharge Instructions:**

**Additional Prescriptions:**

BURN. (6 Refills).Printed.

I understand that the emergency care I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician(s) as indicated for continued and complete medical diagnosis, care, and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the follow-up physician indicated above.

**I have read and understand the above, received a copy of applicable instruction sheets, and will arrange for follow-up care.**

Steve Blevins 9-2-15

Signature Patient/Parent/Guardian Date/Time

J.D.O. 9-2-15

Signature Instructed By Date/Time

Joel A Smithers DO
445 Commonwealth Blvd E
Ste A
Martinsville, VA 24112
(844)373-7883

# Discharge Summary (Chart Copy)

Date: 09/02/2015
Time: 12:06 p.m.

Treating Provider: Joel Smithers, DO  Phone:  Fax:

Provider Signature: <Electronically signed by Joel Smithers,DO.>

Patient Name: Steven Blevins  MR#: 1URXJYH27  Account:

Patient Address:  Phone:

Your Discharge Instructions:

Your Prescriptions:

Diclofenac Sodium 75 Milligram # 60 Tablets
1 TABLET TWICE DAILY AS NEEDED FOR PAIN WITH FOOD AND WATER. (0 Refills).Printed.
Neurontin 600 Milligram # 120 Tablets
1 TABLET 4 TIMES DAILY FOR 30 DAYS (3 Refills).Printed.
Nortriptyline HCl 25 Milligram # 90 Capsules
1 CAPSULE 3 TIMES DAILY (6 Refills).Printed.
Ranitidine HCl 150 Milligram # 60 Tablets
1 TABLET TWICE DAILY AS NEEDED FOR HEART

Physician Name:  Specialty:

Address:  Phone:

Follow-up Notes:

I understand that the emergency care I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician(s) as indicated for continued and complete medical diagnosis, care, and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the follow-up physician indicated above.

**I have read and understand the above, received a copy of applicable instruction sheets, and will arrange for follow-up care.**

Steven Blevins 9-2-15  J. DO. 9-2-15

Signature  Patient/Parent/Guardian  Date/Time  Signature  Instructed By  Date/Time

# Checklist for Long-Term Opioid Therapy

**Patient name:** Steven Blevins 3·3·72

| Workup | Date | Outcome |
|---|---|---|
| Complete medical history | | |
| Complete physical examination | | |
| Assessment of the pain | | |
| Assessment of pain on physical and psychological function | | |
| Assessment of history of substance abuse | | |
| Assessment of Coexisting diseases or conditions | | |
| Documentation on the presence of recognized medical indication for the use of a controlled substance | | |
| Establish goals of opioid treatment | | |
| Risks and benefits communicated | | |
| Written consent or pain agreement (optional, if high risk or history of substance abuse) | | |
| Periodic review of goals | | |
| Monitor compliance | | |
| Consultation as necessary for additional evaluation and treatment | | |
| Accurate and complete records to include medical history, physical examinations, evaluations, consultations, treatment plan objectives, informed consent treatments, medications, rationale for changes in treatment plan, agreements with patient, and periodic reviews of the treatment plan | | |

Reference: Medical Board of California. Department of Consumer Affairs. Guidelines for prescribing controlled substances for pain (2007). http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.aspx. Accessed May 2014